The Children's Commission

CRITICAL INJURY REVIEWS

PROGRAM AREA REPORT

(January 1, 2000 to December 31, 2000)

LEGISLATIVE LIBRARY OF BRITISH COLUMBIA
3 3298 00256 5365

CRITICAL INJURY REVIEWS

One aspect of the mandate of the Children's Commission is reviewing critical injuries of children in government care, and making recommendations, based on these investigations, to enhance the safety and protection of children.

The Children's Commission's authority to investigate critical injuries is limited to those injuries that meet the definition as set out in the *Children's Commission Act*, which defines a critical injury as one that may result in the child's death or cause serious or permanent impairment of the child's physical health.

The Director of Child Protection receives notification from Ministry for Children and Families field offices of reportable circumstances regarding children in care. Reportable circumstances include the death or critical injury of a child in care, and serious incidents including exposure to high-risk or life-threatening circumstances, involvement in crimes of violence, running away, and abuse or neglect while in care. Only a small subset of these reports pertains to the Children's Commission mandate.

During the year 2000, 604 reportable circumstances were reported to the Director of Child Protection. Of these 604 cases, 93 were reported to the Children's Commission as potential critical injuries. Of the 93 cases reported to the Children's Commission, investigations were opened in the 64 cases that met the Children's Commission criteria for critical injury reviews.

Of the 64 critical injury reviews undertaken in 2000, 32 were completed by December 31, 2000. The other 32 cases remained in process, and were completed by February, 2001 (these will be part of the analysis in next year's report).

In the 1999 "Fatalities and Critical Injuries Program Area Report", it was noted that an audit of the Ministry's reportable circumstance records had been conducted in order to determine whether or not all appropriate referrals were being made. This audit resulted in identification of problems in the reporting process, and led to the development of clearer definitions and reporting processes from the Ministry to the Commission for the year 2000.

A similar audit was conducted on Ministry reportable circumstance records from the year 2000, and it demonstrates that reporting has improved significantly. Of the 604 reportable circumstance reports received by the Director, there were 12 cases in addition to the 93 cases reported to the

Children's Commission that should have been referred to the Commission for consideration for critical injury reviews. However, most of these cases were from the early part of the year 2000 when the new definitions and reporting process was being implemented. It is expected that reporting will continue to improve in 2001.

How We Conduct Critical Injury Reviews

For cases reported to the Children's Commission in 2000, reviews have focussed on the safety response and follow-up to the injury incident from the perspective of case management and provision of services to the affected child.

Available documentation is reviewed, and investigators generally interview key staff in the case by telephone. The information is summarized and a written report is provided to the Ministry. These reports include issues identified during the review.

Results of critical injury reviews are summarized and reported annually. Individual case reports are not released publicly, as many of these children and youth are emotionally fragile and publication of private information about their lives could further threaten their health and well being.

For critical injury cases in the year 2001, the review process will be extended to include a comprehensive review of Ministry guardianship of the child throughout the time in care. Such issues as child protection and risk assessment, integrated case management, care planning, placement history, access to required supports and interventions, file recordings and court processes will be examined in a thorough review of all files pertaining to the child. This approach will enable us to make useful recommendations for systemic change.

Analysis of 32 Completed Critical Injury Reviews

Regional Breakdown

Critical injury investigations are underway in cases reported by 10 Ministry for Children and Families regions (numbers in brackets relate to the 32 completed reviews):

North – 7 (9)
Okanagan – 7 (5)
Capital – 2 (4)

Upper Fraser – 3 (4)
Simon Fraser – 4 (2)
Kootenays – 1 (2)
Vancouver/Richmond – 3 (2)
Thompson/Cariboo – 2 (2)
South Fraser – 3 (1)
Central/Upper Island – (1)

Critical Injuries of Youth in Care (age 13 to 18)

Of the 32 completed reviews, 29 involved youth age 13 to 18.

Of the 29 critical injuries involving youth, the nature of the injuries were as follows:

Suicide Attempt – 16
Injuries from Physical Assault – 5
Motor Vehicle Injury – 4
Severe Alcohol Intoxication – 3
Other Accidental Injury – 1

Over half of critical injury cases among youth (16 of the 29) involved injuries resulting from suicide attempt or serious self-harm. Of the 16 youth that attempted suicide, 13 were females, and 4 were Aboriginal youth.

Of these 16 cases, 11 involved drug overdoses with suicidal intent. The other 5 cases involved cutting or slashing with sharp objects.

Most of the suicide attempts were made by youth aged 14 to 17; only 4 of the youth were 18. (This age distribution is also apparent in the suicide cases in which the reviews were not completed by the end of 2000).

It is noteworthy that there was a history of alcohol involvement in the lives of 13 of the 29 youth.

The 5 cases in which injuries resulted from physical assault all involved assaults by other youth. None of these assaults occurred in the youth's placement homes.

Of the 3 youth whose health and safety were put at risk was caused by extreme alcohol ingestion. In one of these cases, there was no known history of prior drinking.

Each of the 4 motor vehicle injuries occurred under different circumstances. In one case, a youth was injured when a car he was travelling in with several other youth went out of control; alcohol was involved in this incident. In another case, a youth was injured when the car he was in, driven by a child care worker, was hit by another vehicle. In the third case, a car struck a youth pedestrian. In the fourth case, a truck hit a youth who rode his bike out from between parked cars.

The other accidental injury involved a fall from a bicycle.

Critical Injuries of Children in Care (Age 6 to 12)

The 2 critical injury cases in this age group both involved accidental injuries. In one case, a child fell from his bicycle; in another case, a pin was accidentally ingested.

Critical Injuries of Children in Care (Age 1 to 5)

The 1 critical injury case in this age group involved ingestion of a toxic substance. A one-year-old was admitted to hospital with severe vomiting and diarrhea, and was later found to have sustained permanent liver damage. It could not be determined how this poisoning occurred.

Issues Identified in Critical Injury Reviews

In 7 of the 32 critical injury reviews, no serious issues with case management were noted. In these cases, based on available information, follow up was appropriate, and there were no outstanding concerns about the management of the case.

In 25 of the 32 critical injury reviews, one or more issues of concern were identified. These included:

- 8 cases in which notification of the Director or the police did not occur, or was not timely, or in which social workers did not attend at hospital.
- 7 cases in which follow up safety planning was deficient or not complete.
- 6 cases in which appropriate services were not available or could not be arranged in a timely fashion.

- 6 cases in which there was a general issue about overall case management.

- 5 cases in which the comprehensive plan of care was incomplete or not up to date.

- 5 cases in which educational needs were not being met or properly planned for.

- 5 cases in which Fetal Alcohol Syndrome/Effect was suspected, but a thorough assessment was not done.

- 4 cases in which a suitable placement was not available or the youth was homeless.

A significant proportion of these cases involve youth who have severe problems, including suicide risk, mental health problems, and alcohol and drug problems. These are undoubtedly some of the most challenging youth that Ministry staff work with. However, there is a need for improvement in how the system responds to these youth. Overall, these reviews demonstrate significant issues in planning for youth in care, and raise concerns about availability of specialized services and appropriate living arrangements to meet their needs.